Revisit Form

Mary Langfield
VITALITY NOW

Date _____ Phone _____

Name _____ Email _____

What positive changes have you noticed since your last session?: _____

What are your main concerns at this time? _____

Any changes with weight? _____

Have you been drinking water? How much? _____

How is your sleep? _____

How has your energy been on a scale of 1 10, 10 being high? _____

Have you experienced any of the following: gas, bloating, diarrhea, constipation? _____

Are you having bowel movements daily? _____

What are they like (SHAPE, COLOR, CONSISTENCY)? _____

How is your mood? _____

Are you cooking more? _____

What's your diet like these days? _____

Breakfasts: _____

Lunch: _____

Dinner: _____

Snacks: _____

Are you experiencing any cravings? _____

What supplements/medications are you currently taking? _____

Anything else you would like to share? _____